

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

 FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES H. ADAMS			2a. DATE OF DEATH MONTH 2 DAY 22 YEAR 84 2b. HOUR 3:00 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Aug. DAY 21 YEAR 1896	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. MONTHS DAYS HOURS MIN.		7. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.		
10. CITY OR TOWN OF DEATH HAVRE DE GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Ohio Bell Operator		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 307 Sheffield Court 21085		
14. FATHER'S NAME FIRST William MIDDLE Miller LAST Miller		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Schultz LAST Schultz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 271-07-7908		17. INFORMANT (Son) ADDRESS James M. Adams Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (I) (we) last saw the deceased alive on above; (b) (we) (did not) view the body after death.					
22b. SIGNATURE Dante M. Monakil		DEGREE MD		22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL		22e. ADDRESS Havre de Grace Md 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/24/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.	
23d. LOCATION CITY OR TOWN Baltimore		COUNTY Md.		STATE	
24. FUNERAL DIRECTOR NAME E. Barnes ADDRESS 21018		25a. DATE REC'D. BY REGISTRAR FEB 23 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked either, it shows any injury, or other traumatic event, the medical examiner must be notified.

Flamingo General Service, Inc.
E. Palmer
2/28/88
Greenwood Gen. Sales

William

Ellis

Blissford

Adams

Ohio

U.S.A.

XX

Female

White

Aug. 21, 1904

87

801 Ohio Bell Operator

307 Sheffield House

Maryland Hartford Johns

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

- STATE OF MARYLAND -
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 4 3 8 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES L. ALBERDING			2a. DATE OF DEATH MONTH 2 DAY 23 YEAR 84			2b. HOUR 1:30 P M		
3. SEX male		4. RACE WHITE		5. DATE OF BIRTH MONTH 10 DAY 01 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford Co. MD.		
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (ret.)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. COUNTY Hartford CITY OR TOWN Bel Air				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 17 Lake Drive 21014		
14. FATHER'S NAME FIRST Charles MIDDLE Alberding LAST Alberding				15. MOTHER'S MAIDEN NAME FIRST Ceascy MIDDLE Burns LAST Burns				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 1942-46 U.S. Army				16b. SOCIAL SECURITY NO. 513-05-9265		17. INFORMANT (wife) ADDRESS Mrs. Alyce J. Alberding Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Cardiac-pulmonary failure. DUE TO, OR AS A CONSEQUENCE OF (b) CVA. ASCVD = cardiomyopathy. DUE TO, OR AS A CONSEQUENCE OF (c) COPD. ACTIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-1 , 19 81 , to 2-23 , 19 84 , that (I) (we) last saw the deceased alive on 2-23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE (Signature)		DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-23-84.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.D. PAREKH MD.				22e. ADDRESS 1908 HARTFORD ROAD, FALLSTON MD. 21047				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/25/1984		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN Baltimore COUNTY Md. STATE Md.		
24. FUNERAL DIRECTOR NAME E. Barnes ADDRESS Fleming Funeral Service - Benson, Md.				25a. DATE REC'D. BY REGISTRAR FEB 27 1984		25b. REGISTRAR'S SIGNATURE (Signature)		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Katherine E. BAIER</i>					26. DATE OF DEATH MONTH DAY YEAR <i>02-19-84</i>			2b. HOUR <i>9⁰⁰ P^M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 04 08</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, Harford MD.</i>			
10. CITY OR TOWN OF DEATH <i>Hydes</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2929 Harford Road, Hydes, Md.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shirt & Sew. Fact.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Hydes</i>		13. STREET ADDRESS <i>2929 Harford Rd. Hydes, Md. 21082</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph H. Hawkins</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen B.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>212-09-7451</i>		17. INFORMANT ADDRESS <i>2929 Harford Rd. Mr. Lawrence F. Baier, Hydes, Md. 21082</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>4920 Cardio pulmonary Arrest</i>								<i>9 pm.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>End-Stage Lung Disease, Chronic Respiratory Failure</i>								<i>2 mo.</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Pulmonary Emphysema</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Aspirational Pneumonia, Cachexia, Urinary Tract Inf.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>in Fallston Hospital 12/10/83</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>DEC. 10, 19 83</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 12 OF PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>DEC. 10, 19 83</i> to <i>Feb. 5, 19 84</i> , that (I) (we) last saw the deceased alive on <i>Feb 5, 19 84</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Albert S. C. Sun, m.d.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>2/20/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albert S. C. Sun, m.d.</i>				22e. ADDRESS <i>1800 Harford Rd, Fallston, MD 21047</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-24-1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Mem. Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bel Air Harford Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 23 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04885

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MAMIE MIDDLE R LAST BARRON			2a. DATE OF DEATH MONTH DAY YEAR Feb. 23 1984		2b. HOUR 8:45 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-14-1890		
6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10. CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		
12b. KIND OF BUSINESS OR INDUSTRY Retired		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Harford		
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4303 Conowingo Rd. - 21034		
14. FATHER'S NAME FIRST August MIDDLE Boss LAST			15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Helmers LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-2998		17. INFORMANT ADDRESS Mrs. Emma R. Otto - 2923 Placid Dr. Md. = 21013		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>End Stage Ischemic Heart Disease</u> years (c) <u>#</u> (prognosis) DUE TO, OR AS A CONSEQUENCE OF						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Aspiration Pneumonia</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Blunt</u>		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) <u>not</u>		
21f. LOCATION CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>84</u> , to <u>2-23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>2/24/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAZATIN, MANUEL</u>		22e. ADDRESS <u>PO Box 519 8 Low St Harford, Md 21061</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>2-25-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>John C. Miller Onc-6415 Belair Rd. - 21206</u>				
25a. DATE REC'D. BY REGISTRAR <u>FEB 27 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after date with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN DAVIS BENTLEY						2a. DATE OF DEATH MONTH DAY YEAR February 29, 1984	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 17, 1920		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jenkins, Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Darlington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2057 Glen Cove Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergyman		12b. KIND OF BUSINESS OR INDUSTRY Church	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Henderson Bentley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Whittaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 406-09-2385		17. INFORMANT ADDRESS Gary Bentley			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) VENTRICULAR TACHYCARDIA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from 2/17 19 84 , to 2/29 19 84 , that (I) (we) last saw the deceased alive on 2/17 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Baby A. Wohl, M.D.				DEGREE MD		22c. DATE SIGNED 2-29-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Baby A. Wohl, M.D.				22e. ADDRESS 131 S. Union Ave, Havre de Grace, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 3, 1984		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR MAR 2 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-10-2010 BY 60322

11/10/2010

1

THESE DOCUMENTS
WAS THE FIRST
OF THE FIRST

2010
11/10/2010

NOV 10 2010

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GEORGE CONLEY BLEVINS			2a. DATE OF DEATH MONTH FEB. DAY 21, YEAR 1984		2b. HOUR 5:05 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH FEB. DAY 15 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			10. CITY OR TOWN OF DEATH EDGEWOOD		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) 2018 STARR STREET			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION
13a. STATE MARYLAND			13b. COUNTY HARFORD	13c. CITY OR TOWN EDGEWOOD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST WILLIAM MIDDLE LAST BLEVINS			15. MOTHER'S MAIDEN NAME FIRST MAUDE MIDDLE LAST PENNINGTON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 229-12-5627		17. INFORMANT ADDRESS 2018 STARR ST. EDGEWOOD, MD. 21040
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF COPD (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) 					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/14 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/14 19 1984 to 2/21/84 19 , that (I) (we) lost sight of the deceased above 3/21/84 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We would not view the body after death.)					
22b. SIGNATURE Louis E. Kahan				22c. DATE SIGNED 2/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS E. KAHAN M.D.				22e. ADDRESS TRIMBLE RD. EDGEWOOD MEDICAL CENTER EDGEWOOD, MD. 21040	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-14-84		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEM. GDS.	
24. FUNERAL DIRECTOR NAME HOWARD K. MCCOMAS III ADDRESS ABINGDON, MARYLAND		25a. DATE REC'D. BY REGISTRAR FEB 23 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only for retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

UNCLASSIFIED COPY
DATE 10/10/2000 BY SP-10/2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 04888			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				20. DATE OF DEATH MONTH DAY YEAR			
Walter W. Bosman, Sr.				2/21/84			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.	
male		White		5 15 1933		50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Harford County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hosp.		Self-Employed		Furniture	
13a. STATE				13b. COUNTY			
Maryland				Baltimore			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Perry Hall				4 Forge Hill Road 21128			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Charles Bosman				Effie Price			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
Yes		Korea		219-30-1689 Virginia M. Bosman-Balto., MD. 21128			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Cardiac Arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Severe coronary art							
DUE TO, OR AS A CONSEQUENCE OF (c) Disease -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diab Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1983 to Feb 1984, that (I) (we) lost saw the deceased alive on 2-21-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
V. S. NAIR, M.D.		27161444 Road, Fallston MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/24/1984		Bel Air Memorial		Bel Air Harford Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
7922 Wise Avenue Dundalk, MD. 21222				FEB 23 1984			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 4 8 8 9

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Walter Boyle		MONTH DAY YEAR Feb. 22, 1984	
2b. HOUR 11:20 PM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	MONTH DAY YEAR Feb. 22, 1919	65 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	United States		Harford County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
White Hall	2753 East Church Lane	Farmer	Agriculture
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Harford	White Hall	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
FIRST MIDDLE LAST Cleveland Boyle	FIRST MIDDLE LAST Inez Orr	2753 East Church Lane	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No	161-20-0061	Lillian A. Boyle White Hall, MD 2753 East Church Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Motablate Co. from</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Colon Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>1 yr.</u>
MEDICAL CERTIFICATION			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> 19 <u>78</u> to <u>2-23</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-20</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
<u>William O. Fulton MD</u>			<u>2-23-84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
<u>WILLIAM O FULTON</u>	<u>21 Fulton Ave Stewartstown Pa</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb. 27, 1984	Slate Ridge	Peachbottom Twp. York PA
24. FUNERAL DIRECTOR NAME ADDRESS			
John H. Harkins 600 Main Street Delta, PA			

FEB 27 1984

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Handwritten notes and a table on lined paper. The notes are mostly illegible due to fading. A table with multiple columns and rows is visible in the lower half of the page.

Film G588 Item 2b, 16b, 17

FOR
1 - STATE
REGISTRAR

2/17/84 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sebert Dewey Brinegar			2a. DATE OF DEATH MONTH DAY YEAR Feb. 3 1984		2b. HOUR 6:32 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1908		
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		10. CITY OR TOWN OF DEATH Harke de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY US-govt. Ret.		13a. STREET ADDRESS / ZIP CODE 200 Broadview Ave., 21014		
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Preston Brinegar		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Lucinda Kessling		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-0811		17. INFORMANT NAME ADDRESS Mrs. Patty Brinegar, 10 Dublin Way, Bel Air, Md. 21014		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small Cell Carcinoma of lung with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral metastasis & Respiratory insufficiency</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>84</u> , to <u>2-3</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Murli Mathur</u>		DEGREE M.D.		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURLI MATHUR, M.D.		22e. ADDRESS 1305 Fallston Rd, Fallston md 21047				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Harford Md.		
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009				
25a. DATE REC'D. BY REGISTRAR FEB 6 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

04891

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARL E. BUSIC			2a. DATE OF DEATH MONTH 2 DAY 5 YEAR '84 2b. HOUR 11:00 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 12 DAY 24 YEAR 21	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CON'CT
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY CECIL 13c. CITY OR TOWN RISING SUN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST FRANK MIDDLE BUSIC LAST BUSIC			15. MOTHER'S MAIDEN NAME FIRST DORA MIDDLE MULLINS LAST MULLINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 242-22-3673		17. INFORMANT MAZIE B. BUSIC ADDRESS RISING SUN MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car to respiratory arrest 4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic hypothyroidism & diabetes mellitus				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE ON A WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (I) (this hospital) attended the deceased from 2/4 19 84 to 2/5 19 84 , that (I) (we) last saw the deceased alive on 2/4 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (only) (did not) view the body after death.				
23a. SIGNATURE [Signature]		DEGREE		23b. DATE SIGNED 2/4/84
24. PHYSICIAN'S NAME (TYPE OR PRINT) AMA KAWA M.D.		25a. ADDRESS 319 S. Union Mt. Hwy Md. 21078		
26a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	26b. DATE 2-8-84	26c. NAME OF CEMETERY OR CREMATORY PINEY CREEK		26d. LOCATION CITY OR TOWN COUNTY STATE PINEY CREEK
27. FUNERAL DIRECTOR NAME R. T. FORD ADDRESS FUNERAL HOME MD		28. DATE REC'D. BY REGISTRAR FEB 8 1984		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED
JAN 10 1968
FBI - NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [illegible]
[illegible]

[Extremely faint, mostly illegible text block containing several paragraphs of a memorandum or letter. Some words like "subject", "information", and "report" are faintly visible.]

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [illegible]
[illegible]

DATE: [illegible]
[illegible]
[illegible]

[Faint header text, possibly "BUREAU OF INVESTIGATION"]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY G. CANADA			2a. DATE OF DEATH MONTH DAY YEAR 2-8-84			2b. HOUR 2 ^{am} _m	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 2 14 06	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
10. CITY OR TOWN OF DEATH Anne De Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Perryman	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Railroad Ave. 21130			
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Grovenstine		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Rebecca Russell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-07-1902		17. INFORMANT ADDRESS Perryville, MD, 21903 Connie Higgins, 1010 Frenchtown Rd.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASHD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Metastatic Carcinoma of the Colon							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-12 19 83 to 2-8 19 84 , that (I) (we) lost saw the deceased alive on 2-6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Howlett Jackson				DEGREE M.D.		22c. DATE SIGNED 2-8-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howlett Jackson M.D.				22e. ADDRESS 1315 Union Ave Harre De Grace Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 10, 1984		23c. NAME OF CEMETERY OR CREMATORY Spesutia Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE Perryman, Harford, Maryland	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				25. DATE REC'D. BY REGISTRAR FEB 14 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			

RECEIVED
FEB 14 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

100-100000

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 4 8 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Theresa LAST Cooper Mary Theresa Cooper			2a. DATE OF DEATH MONTH DAY YEAR 02 02 84			2b. HOUR 3:10 a.m.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 7, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4029 E. Baker Ave. 21009		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Denmead Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara --0-- Miller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --				16b. SOCIAL SECURITY NO. 213-74-0045		17. INFORMANT ADDRESS Mrs. Margaret L. Caron, 4029 E. Baker Ave, Abingdon, Md. 21009				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Old age DUE TO, OR AS A CONSEQUENCE OF (b) Recent Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John D. Yun						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/2/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John D. Yun						22e. ADDRESS Havre de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 6, 1984			23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington-Arlington, Va.	
24. FUNERAL DIRECTOR H.K. McCOMAS ABINGDON, MARYLAND						25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE John J. Carver		

MEDICAL CERTIFICATION

99

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

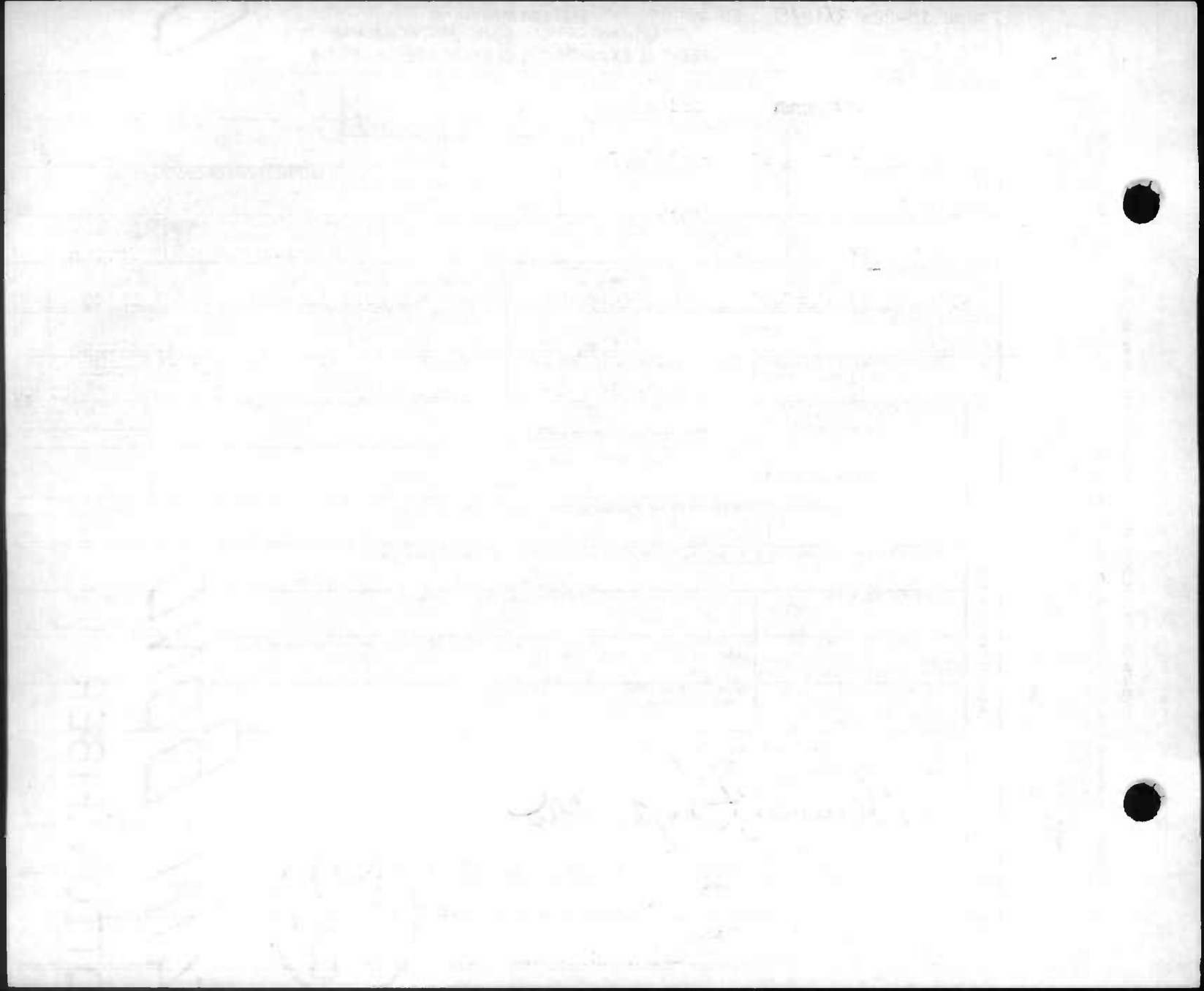
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 18-22a 3/12/84 mtb F#589

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Deborah Anita David			XX MONTH DAY YEAR 2-18 19 84			M		
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR	
Female	White	MONTH DAY YEAR 11 9 1953	30 YRS.	MONTHS DAYS HOURS MIN.		2-18 19 84	12:03 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.					Harford County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Fallston	Fallston General Hospital			Partner		Tavern		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Harford	Edgewood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	331 Laburnum Road 21040			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Melvin J. Hittle, Sr.			Ethel A. Kowalczyk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			214-54-4436		Raymond David 331 Laburnum Rd. Edgewood, MD 21040			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4850 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
<i>Dennis F. Smyth, M.D.</i>			M.D. Assistant			2-19-84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Dennis F. Smyth, M.D.			111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		2/22/84	Sacred Heart of Jesus		Dundalk, Baltimore, MD			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Duda-Ruck, Inc.			7922 Wise Avenue, Dundalk, MD 21222		FEB 23 1984			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						4895					
1. DECEASED NAME (TYPE OR PRINT) Glenneth O. Dixon						2a. DATE OF DEATH MONTH DAY YEAR 2 / 23 / 84				2b. HOUR 9:05 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD					
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 701 Market Street 21078			
14. FATHER'S NAME FIRST MIDDLE LAST Walter W. Noel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bias							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-8269		17. INFORMANT ADDRESS Maryland 21078 Monroe J. Dixon, 701 Market St., Havre de Grace							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac decompensation DUE TO, OR AS A CONSEQUENCE OF (c) Multiple cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Generalized cerebral sclerosis & 20 years of senility											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 10-4 19 83 to 2/23 19 84 , that (1) (we) last saw the deceased alive on 2/23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE				22c. DATE SIGNED 2/23/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. H. Anderson M.D.				22e. ADDRESS 319 So. Union Ave. Havre de Grace MD 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 26 Feb. 84		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace Harford MD					
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD				25a. DATE REC'D. BY REGISTRAR FEB 28 1984				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

1. The first part of the document is a letter from the President of the United States to the President of the Senate, dated January 1, 1901. The letter is signed by William McKinley and is addressed to John D. Long. The letter is a copy of a letter that was sent to the President of the Senate by the President of the United States. The letter is a copy of a letter that was sent to the President of the Senate by the President of the United States. The letter is a copy of a letter that was sent to the President of the Senate by the President of the United States.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Troy Felix Douglas		2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		5-20-98	
6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
85		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
N.C.		USA		NEVER MARRIED	
9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY	
HARFORD		Laborer Ret.		Gen. Work	
12. CITY OR TOWN OF DEATH		13. INSIDE CITY LIMITS?		14. STREET ADDRESS	
Harford		YES		561 Rising Sun Rd.	
15. FATHER'S NAME		16. MOTHER'S MAIDEN NAME		17. INFORMANT	
Joseph Douglas		Alice VanHoy		Hospital Chart	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES?		18b. SOCIAL SECURITY NO.		18c. ADDRESS	
No		197-05-4970		Hospital Chart	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
4140 IMMEDIATE CAUSE (a) CORONARY Heart Disease					
DUE TO, OR AS A CONSEQUENCE OF					
ASCUD					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES NO X	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
NOT WHILE AT WORK				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Luis E Renjel		M.D. Deputy		3-12-84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		HARFORD	
Luis E Renjel		464 Alliance St		Harford	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Feb. 14, 84		New Bridge Baptist Cem.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Richard L. Goodie		FEB 15 1984		John Davidson	

100-100

100-100

100-100

100-100

100-100

BP

DHMH - 16 50M 4/82
(VIA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ELEANOR ALLEN DVORAK				2a. DATE OF DEATH MONTH DAY YEAR 02 07 84			
3. SEX FEMALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12 14 09		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas V. Allen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Williamina Ure			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-10-164		17. INFORMANT ADDRESS THOMAS DVORAK 2401 STONEY BROOK RD 21047 FALLSTON, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock 2765 DUE TO, OR AS A CONSEQUENCE OF (b) gm-negative Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/3 19 84 , to 2/7 19 84 , that (I) (we) last saw the deceased alive on 2/6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Andrew Nowakowski MD				DEGREE MD		22c. DATE SIGNED 2/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD				22e. ADDRESS 125 N. MAIN ST. BEL AIR, MD 21034			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/10/84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 8 1984			
				25b. REGISTRAR'S SIGNATURE John J. Smith			



REC'D COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Agnes Petrovella Gaygardt</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>2 2 84</i>		2b. HOUR <i>M.</i>			
3 SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>5 31 10</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford County MD.</i>					
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>C & P</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Worcester</i>		13c. CITY OR TOWN <i>Ocean City</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>106 Clam Shell Rd. 21842</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrew M. Burton</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary J. Regel</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-05-1087</i>		17. INFORMANT ADDRESS <i>Ocean City Md. 21842</i> <i>Joseph T. Gaygardt 106 Clam Shell Rd.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>2050 Ac. Blast Crisis & Gen. leukemic infiltration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Myelocytic Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>amputable</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY P.M. <i>1984</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>1984</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan - 1980</i> , to <i>2-2-1984</i> , that (I) (we) last saw the deceased alive on <i>2-2-1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.											
22b. SIGNATURE <i>John Mathur</i> DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MURLI MATHUR, MD</i>				22e. ADDRESS <i>1305 Fallston Rd, Fallston md - 21041</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Feb 6 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc.</i>				ADDRESS <i>Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

BP _____

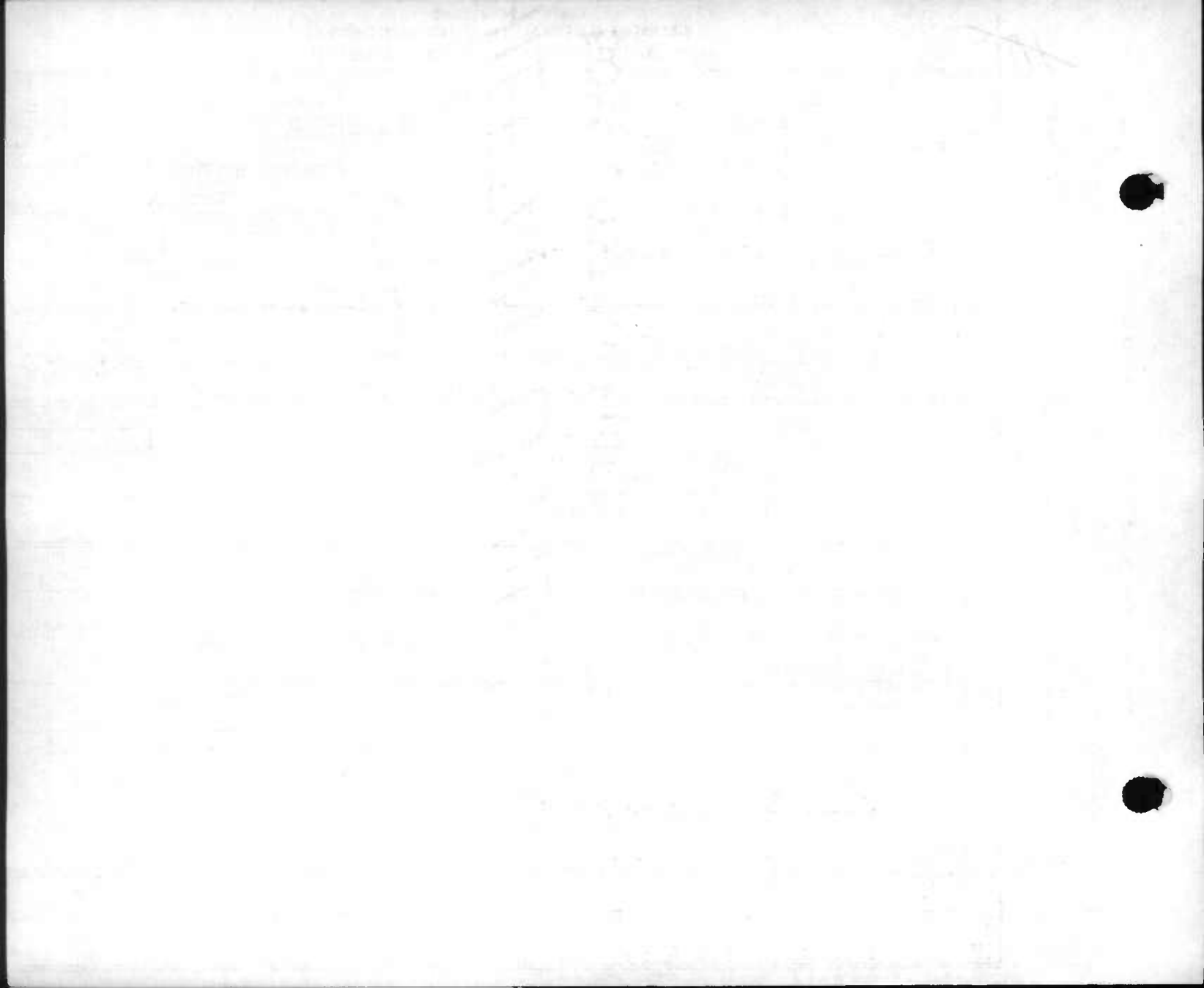
5782 • J. Neurosci., September 24, 2008 • 28(39):5775–5785

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Rita Cecilia Gjerulff										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-20 19 84 0 30 a.m.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 31 27		6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2-20 19 84 3 30 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1338 Gateshead DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD				13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21014 1338 Gateshead Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD WELLER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET FEENEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT 4404 ADDRESS 4404 CLIFTON SPRING CT. RICHARD M. GJERULFF JR. OLNEY, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) Deputy				DATE SIGNED 2-20-84			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St. Havre De Grace, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE FEB. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY CRATIN & FERRIS		23d. LOCATION CITY OR TOWN COUNTY STATE WEST CHESTER CHESTER PA.			
24. FUNERAL DIRECTOR NAME ADDRESS HOWARD K. MCCOMAS III ABINGDON, MARYLAND						25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE Johanna Davidson-Nelson			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Manly L. Harrell					2a. DATE OF DEATH MONTH DAY YEAR Feb 9 1984			2b. HOUR 4:01 PM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR JULY 24, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. # UNDER 1 YEAR MONTHS DAYS 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE MD.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13e. STREET ADDRESS / ZIP CODE 1110 Revolution St. 21078			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES W. SCOTT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE F. REASON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 239 38 0648		17. INFORMANT ADDRESS MR. JAMES B. HARRELL SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Infarctable Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (c) CAD, CVA, S/P Endarterectomy, Bleeding PUP								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/31 , 19 84 , to 2-9 , 19 84 , that (I) (we) lost saw the deceased alive on 2-9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. H. CALON				22e. ADDRESS 611 S. UNION AVE. HAVRE DE GRACE MD 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 13 FEBRUARY 84		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE ABERDEEN HARFORD CO. MARYLAND			
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078					25. DATE RECEIVED FEB 15 1984				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRS 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04901

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW F HENSON		2a. DATE OF DEATH MONTH DAY YEAR 2 22 84	
3 SEX M		2b. HOUR 3:42 PM	
4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 7 1888	
6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Harford	
13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 1600 Hollingsworth Rd. 21085			
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Henson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Scott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-28-1580	
17. INFORMANT ADDRESS Mary E. Demby same as above			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4269 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) heart block, 2nd degree, atrial flutter APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3:42 PM 6-7 yrs			
PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile age			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 20, 19 84, to Feb 22, 19 84, that (I) (we) last saw the deceased alive on 2/22/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE Albert Sun, M.D.		22c. DATE SIGNED 2/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Sun, M.D.		22e. ADDRESS 1800 Harford Rd. Fallston 21047	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/84	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion United Meth		23d. LOCATION CITY OR TOWN COUNTY Joppa Harford Md.	
24. FUNERAL DIRECTOR Arnold Beard 353 Fountain St. Havre de Grace Md.		25a. DATE REC'D. BY REGISTRAR FEB 29 1984	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Elina Hill				2a. DATE OF DEATH MONTH DAY YEAR Feb. 14, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 27, 1913		2b. HOUR 1:05 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Finland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Whiteford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1900 Deep Run RD		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Harford Whiteford				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Victor Manning				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amalia Kakkonen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-32-9216		17. INFORMANT ADDRESS Matthew Hill 1900 Deep Run RD, Whiteford, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infection</u> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cause of the Reaction with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <u>2</u> , 19 <u>79</u> , to <u>2/15</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Janne Olson				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janne Olson				22e. ADDRESS Webb Lane, Fawn Grove, Pa., 17321			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY Cratin & Ferris		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa.	
24. FUNERAL DIRECTOR NAME John Harkins				ADDRESS 600 Main St. Delta, Pa		25. DATE REC'D. BY REGISTRAR FEB 21 1984	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randell			

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Date		Description		Amount	
1900	Jan 1	Balance		100.00	
1900	Jan 15	Interest		5.00	
1900	Feb 1	Interest		5.00	
1900	Feb 15	Interest		5.00	
1900	Mar 1	Interest		5.00	
1900	Mar 15	Interest		5.00	
1900	Apr 1	Interest		5.00	
1900	Apr 15	Interest		5.00	
1900	May 1	Interest		5.00	
1900	May 15	Interest		5.00	
1900	Jun 1	Interest		5.00	
1900	Jun 15	Interest		5.00	
1900	Jul 1	Interest		5.00	
1900	Jul 15	Interest		5.00	
1900	Aug 1	Interest		5.00	
1900	Aug 15	Interest		5.00	
1900	Sep 1	Interest		5.00	
1900	Sep 15	Interest		5.00	
1900	Oct 1	Interest		5.00	
1900	Oct 15	Interest		5.00	
1900	Nov 1	Interest		5.00	
1900	Nov 15	Interest		5.00	
1900	Dec 1	Interest		5.00	
1900	Dec 15	Interest		5.00	
1900	Total			100.00	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARY RECILIA HOLDER			2a. DATE OF DEATH MONTH 2 DAY 28 YEAR 84 2b. HOUR 9:20 P.M.		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 12 DAY 03 YEAR 00		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor		12b. KIND OF BUSINESS OR INDUSTRY Prop.
13a. STATE md.			13b. COUNTY HARFORD	13c. CITY OR TOWN BELAIR	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Timothy William MIDDLE Leo LAST O'Hayer			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Agnes LAST Peters		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-28-5994		17. INFORMANT Mrs. Catherine E. Smith, 1630 Michelle Court Forest Hill, Md 21050	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4860 IMMEDIATE CAUSE (a) **Pneumonia**
DUE TO, OR AS A CONSEQUENCE OF
(b) **CH F**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHyes
days.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE DL VASSAR		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DL VASSAR		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 7, 1984	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION CITY OR TOWN Arlington COUNTY Arlington STATE Va
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009 ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 6 1984 25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 COTTON

WATER TANK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed within 72 hours after death. Page 4 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

4904

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie NMN Huff			2a. DATE OF DEATH MONTH DAY YEAR Feb 1 1984		2b. HOUR 5 ²⁵ P.M.
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 8 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ala.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MINER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Harford	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Abe Huff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Kelly		13e. STREET ADDRESS / ZIP CODE 614 Third St. 21005	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 424-14-6330		17. INFORMANT ADDRESS MRS. Emma Huff 51A	
18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS O.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 20</u> , 19 <u>84</u> , to <u>Feb 1</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>Feb 1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>J. F. Lee</u>		DEGREE		22c. DATE SIGNED <u>2/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. F. Lee</u>		22e. ADDRESS <u>Union Med. Clinic, Harre de Grace</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>2/14/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Pl.</u>	
23d. LOCATION CITY OR TOWN <u>Cockeysville</u>		23e. COUNTY <u>Harford</u>		23f. STATE <u>Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Chatman-Harris FH</u>		ADDRESS <u>1701 McCulloh St</u>		25. DATE REC'D. BY REGISTRAR <u>FEB 07 1984</u>	
25a. REGISTRAR'S SIGNATURE <u>John J. Smith</u>					

MEDICAL CERTIFICATION

27

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FEB 01 1984

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04905

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mae Hasson Hutchens			2a. DATE OF DEATH MONTH DAY YEAR Feb. 23 1984		2b. HOUR P M 7:50 P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-25-1913		6. AGE (IN YEARS LAST BIRTHDAY) 70		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) School Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY Ret.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13a. COUNTY 13a. CITY OR TOWN MD. Cecil Rising Sun				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 700 Biggs Hwy. 21911			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Hosson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Ramsey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-14-4406		17. INFORMANT ADDRESS Vettie Nastri (sister) Wilmingtor Del.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia + Cardiac arrest 4275 DUE TO OR AS A CONSEQUENCE OF (b) malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE John D. Yun				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22b. DATE SIGNED 2/23/84	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN				22d. ADDRESS Harre de Grace, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-27-1984		23c. NAME OF CEMETERY OR CREMATORY Rose Bank Cem.		23d. LOCATION CITY OR TOWN COUNTY Colvert Cecil MD.			
24. FUNERAL DIRECTOR NAME Richard L. Goodie				ADDRESS Rising Sun, MD		25a. DATE REC'D. BY REGISTRAR FEB 29 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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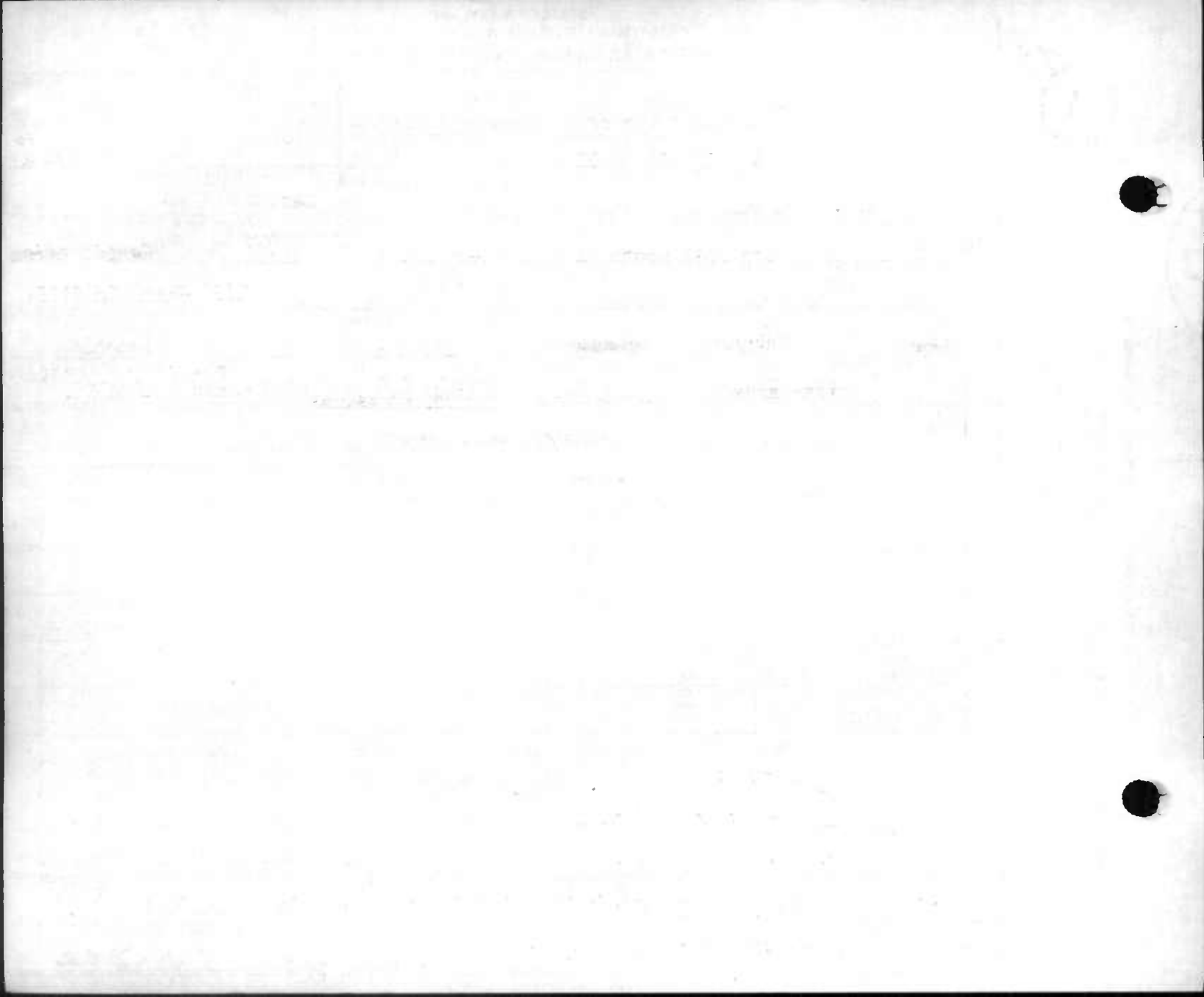
FEB 2 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										4906	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Zillery Cleo Ingool										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2 9 84	
3. SEX M										2b. HOUR 11 p.m.	
4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 1 12		6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS.		IF UNDER 1 YR. MONTHS DAYS 71		IF UNDER 24 HRS. HOURS MIN. 71		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 10 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		MD.		2d. HOUR 12 a.m.	
10. CITY OR TOWN OF DEATH Street		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 3511 Route #2 Mill Green Rd.				12a. USUAL OCCUPATION (TYPE OF WORK) Carpenter Retired		12b. KIND OF BUSINESS OR INDUSTRY Construction		MD.	
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS as above		13f. STREET ADDRESS Mill Green Rd 21154	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche NMN Ingool							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 211-31-994x		17. INFORMANT Ronald J. Ingool		ADDRESS Cardiff Md. 21024		4604 Green Marble Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Luis E. Renjel</i>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 2-10-84			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St. Havre De Grace, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.		21078			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>L. Davidson-Rendall</i>			

FEB 14 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 4907									
1. DECEASED NAME (TYPE OR PRINT) Estella I Jenifer										2a. DATE OF DEATH MONTH February DAY 1 YEAR 1984										2b. HOUR 3:45 AM									
3. SEX Female					4. RACE Black					5. DATE OF BIRTH MONTH 9 DAY 8 YEAR 1914					6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS					7. UNDER 1 YEAR MONTHS 0 DAYS 0					8. UNDER 72 HRS. HOURS 0 MIN. 0				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.														
10. CITY OR TOWN OF DEATH Havre de Grace					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hospital															12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.					13b. COUNTY Hartford					13c. CITY OR TOWN HavreDeGrace					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 100 Revolution St. 21078									
14. FATHER'S NAME FIRST Benjamin MIDDLE Cain LAST Cain										15. MOTHER'S MAIDEN NAME FIRST Pearline MIDDLE Pearline LAST Pearline																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 218-18-2844A					17. INFORMANT ADDRESS Christine Williams 355 Wilson St. HDG, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car fire arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac decompensation DUE TO, OR AS A CONSEQUENCE OF (c) Acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic cardiovascular disease, Diabetes mellitus																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from 1-25 19 84 to 2-1-84 19 84 , that (II) (we) lost above the deceased upon an 2-1-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.																													
22b. SIGNATURE [Signature]										DEGREE [Signature]										DATE SIGNED 2/1/84									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Arnold Beards M.D.										22d. ADDRESS 319 S. Union Ave Hdg Md. 21078																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 2/6/84					23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery					23d. LOCATION CITY OR TOWN Darlington COUNTY Hartford STATE Md.														
24. FUNERAL DIRECTOR Arnold Beards HavreDeGrace, Md.										25a. DATE REC'D. BY REGISTRAR FEB 14 1984										25b. REGISTRAR'S SIGNATURE Davidson-Randall									

BP

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY



TO THE DIRECTOR
OF THE DIVISION OF THE PHYSICAL SCIENCES
FROM THE DEPARTMENT OF CHEMISTRY
SUBJECT: [illegible]

RE: [illegible]
DATE: [illegible]

[illegible handwritten text]

[illegible handwritten text]

Very truly yours,
[illegible signature]
[illegible name]
[illegible title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 04908							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard Joseph Johnson					2a. DATE OF DEATH MONTH DAY YEAR Feb. 22 1984			2b. HOUR 10:10 P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 6, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREIGN MATERIAL SPEC		12b. KIND OF BUSINESS OR INDUSTRY FEDERAL GOVT.	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P O BOX 95 912 EUGENE DR. 21078	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT M. Johnson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE SIPPS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218 07 0904		17. INFORMANT ADDRESS MRS. MARGARET C. JOHNSON SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car to respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease from 4110 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Myocardial infarction with ventricular fibrillation									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not touch the body after death.									
22a. SIGNATURE H. TAKAKAWA M.D.					DEGREE		22b. DATE SIGNED 2/22/84		
22c. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 319 So. Union Ave. Harford 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 25 FEBRUARY 84		23c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE ABERDEEN, HARFORD CO., MARYLAND			
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD 21078					25a. DATE REC'D. BY REGISTRAR FEB 27 1984				

There are several reasons why
the construction of the
new road is necessary
and it is hoped that
the government will
be able to finance it.

It is also hoped that
the government will
be able to finance it.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 04909

1. FOR STATE REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST
FRANCES ELIZABETH JONES

2a. DATE OF DEATH MONTH DAY YEAR
2 21 84

2b. HOUR
1:45 PM

3. SEX Female

4. RACE Caucasian

5. DATE OF BIRTH MONTH DAY YEAR
Sept. 10, 1928

6. AGE (IN YEARS LAST BIRTHDAY) 55

IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.

10. CITY OR TOWN OF DEATH FALLSTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager

12b. KIND OF BUSINESS OR INDUSTRY Insurance

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Harford

13c. CITY OR TOWN Bel Air

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS 21014 914 Prospect Mill Road

14. FATHER'S NAME FIRST MIDDLE LAST
Kinsey Amoss Standiford

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Agnes Louise Coe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No

16b. SOCIAL SECURITY NO. 218-26-5305

17. INFORMANT ADDRESS same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest, 2 Met. U. Breasts Ca
1749
DUE TO, OR AS A CONSEQUENCE OF (b) 2 Breast metastasis and cerebral Edema & Haemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1-27-1984 to 2-21-1984, that (I) (we) lost the deceased on 2-21-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Muri Mathur MD DEGREE

22c. DATE SIGNED 2-21-84

22d. PHYSICIAN'S NAME (TYPE OR PRINT) MURI MATHUR, MD

22e. ADDRESS 1305 Fallston Rd, Fallston Md 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 2/24/1984

23c. NAME OF CEMETERY OR CREMATORY Baptist View Cem.

23d. LOCATION CITY OR TOWN COUNTY STATE
Forest Hill, Harford, Md.

24. FUNERAL DIRECTOR NAME ADDRESS
M. Gladden Kurtz Jarrettsville, Md.

25a. DATE RECEIVED BY REGISTRAR FEB 24 1984

25b. REGISTRAR'S SIGNATURE Julian Davidson

20% COLLOID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 4 9 1 0
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Giles Harding Jones		2a. DATE OF DEATH MONTH DAY YEAR 2 13 84		2b. HOUR 1 45 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 08 09 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Jarrettsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Powers		13e. STREET ADDRESS 3153 Rocks Chrome Hill Rd.		13f. CITY OR TOWN 21084	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-8915		17. INFORMANT Alice L. Jones		ADDRESS same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, acute DUE TO, OR AS A CONSEQUENCE OF (b) 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arteriosclerotic cardiovascular disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 22 19 83 to Feb 13 19 84 , that (I) (we) lost the deceased alive on Feb 11 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Ben Oley		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEN OLEY		22e. ADDRESS 1131 BALTIMORE PIKE, BEL AIR, Md. 21014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/16/1984		23c. NAME OF CEMETERY OR CREMATORY William Watters		23d. LOCATION CITY OR TOWN COUNTY STATE Coopstown, Harford, Md.	
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz		ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

BP

FOR
STATE
REGISTRAR#5, Film G589 3/19/84 kam
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL R KEEN			2a. DATE OF DEATH MONTH DAY YEAR 2 26 1984		2b. HOUR P M 9:15 P		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 26 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD CECIL PERRYVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 417 E. ELM 21903	
14. FATHER'S NAME FIRST MIDDLE LAST W. LOUIS RYAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORA C. WHITE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 213 76 2820		17. INFORMANT ADDRESS W. PAUL KEEN PERRYVILLE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary failure 4292 DUE TO, OR AS A CONSEQUENCE OF: (b) AS GAD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CBS & Gastrostomy feeding DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.							
22b. SIGNATURE J. Lee				DEGREE M.D.		22c. DATE SIGNED 3/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Lee				22e. ADDRESS Union Med. Clinic Havre de Grace			
23a. BURIAL, CREMATION, REMOVAL (CHECK BY) BURIAL		23b. DATE 2-29-84		23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW		23d. LOCATION CITY OR TOWN COUNTY STATE RISING SUN CECIL MD	
24. FUNERAL DIRECTOR NAME ADDRESS R.T. FORD FUNERAL HOME MD				25a. DATE REC'D. BY REGISTRAR MAR 01 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 about any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

4912

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		FEBRUARY 18, 1984		11:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MAKE		WHITE		MONTH DAY YEAR JULY 16, 1903		80 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
NEW JERSEY		USA				HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HAVRE de GRACE		953 NENA AVENUE		DENTIST		PRIVATE PRACTICE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
13a. STATE		HARFORD		HAVRE de GRACE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE		21078	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		953 NENA AVENUE			
FERINAND N. KOHLER		MARIA LIESS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		213 38 8672		MRS. ANN GRIENINGER		SAME AS #13e	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
JOHN D YUN		MD		2/18/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JOHN D YUN		Havre de Grace, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		21 FEBRUARY 84		ANGEL HILL CEMETERY		HAVRE de GRACE, HARFORD CO., MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE RECEIVED BY REGISTRAR (BY PHYSICIAN OR FUNERAL DIRECTOR)			
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				FEB 22 1984			

BP

6

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ANS

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Handwritten text at the bottom left, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 4 9 1 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Bewlah P Koonce</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>Feb. 6 1984</u>		2b. HOUR <u>10:25 P</u>
3. SEX <u>F</u>	4. RACE <u>B</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>4 6 23</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>60</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Miss.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harford</u> MD.		
10. CITY OR TOWN OF DEATH <u>Harre de Grace</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Harford Memorial Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>Md.</u>		13b. COUNTY <u>Harford</u>	13c. CITY OR TOWN <u>Aberdeen</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>63 Liberty St. 21001</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Sullivan Patterson</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lillie</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>425-38-6915</u>		17. INFORMANT ADDRESS <u>J.C. Koonce same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>5621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>PERFORATED TRANSVERSE COLON</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIVERTICULITIS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 wks</u> <u>4 wks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Pneumonia</u>					
19a. DATE OF OPERATION <u>2/6/84</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Drainage of Abscess</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-84</u> , to <u>2-6-84</u> , that (I) (we) last saw the deceased alive on <u>2-6-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>2/7/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Amelito P. Canlas</u>		22e. ADDRESS <u>504 Lewis St, Havre de Grace, Md 21078</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>2/10/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23d. LOCATION CITY OR TOWN <u>Arlington</u>		COUNTY <u>Va.</u>		STATE	
24. FUNERAL DIRECTOR <u>Arnold Beard 353 Fountain St. HavreDeGrace, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 14 1984</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST Mary J. (WILSON) Lieske						2 1 84		6:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR OCTOBER 18, 1896		87 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				Harford MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Havre de Grace		Citizens Nursing Home									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
(RET) PRESSER		LAUNDRY CO,									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21078	
MD		HARFORD		HAVRE de GRACE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		719 OTSEGO STREET			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST JOHN EDWARD WILSON				FIRST MIDDLE LAST LYDIA SHINBERGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		220 01 1305		WILSON LIESKE 327 BUSH CHAPEL RD. ABERDEEN, MD 21001							
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency</u> 2500 DUE TO, OR AS A CONSEQUENCE OF <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Diabetic mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension, arteriosclerosis, cardiovascular disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>84</u> , to <u>2-1</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		DATE SIGNED <u>2-1-84</u>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS									
J. H. K. K. K.		M.O. 519 So. Lincoln Ave. H.S. Md. 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL		4 FEBRUARY 84		ANGEL HILL CEMETERY		CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD, MARYLAND					
24. FUNERAL DIRECTOR				24b. ADDRESS				24c. DATE RECEIVED BY REGISTRAR			
NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078								FEB 6 1984			



RECEIVED
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ST. LOUIS, MO.

FEBO 20 1906

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DHMH - 16 50M 4/B2
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret I. Lindeman				2a. DATE OF DEATH MONTH DAY YEAR 2 14 84			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 23, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY In Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland	
14. FATHER'S NAME FIRST MIDDLE LAST William Yates				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Evans			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Mrs. Suzanne Howell, Bel Air, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, acute</u> 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arteriosclerotic cardiovascular disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 13, 1984</u> to <u>Feb 14, 1984</u> , that (I) (we) last saw the deceased alive on <u>Feb 13, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>BEN OLEYZA</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEN OLEYZA		22e. ADDRESS 1131 BALTIMORE PIKE, Bel Air, Md. 21034					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-17-1984		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, ADDRESS Cumberland, Md. 21				25a. DATE REC'D. BY REGISTRAR FEB 21 1984			
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, except that it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Vincent Mancuso					2a. DATE OF DEATH MONTH 2 DAY 11 YEAR 84					2b. HOUR 12:00 N
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 12 DAY 8 YEAR 1888		6. AGE (IN YEARS LAST BIRTHDAY) 95		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS. HOURS 0 MIN. 0
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
12. CITY OR TOWN OF DEATH Fallston		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber Supplies		15. KIND OF BUSINESS OR INDUSTRY Self-employed		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY Baltimore		16c. CITY OR TOWN		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS 12717 Fork Rd. 21051		
17. FATHER'S NAME FIRST Graziano MIDDLE Mancuso LAST Mancuso					18. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Redolfo LAST Redolfo					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		19b. SOCIAL SECURITY NO. 216-32-8804		19c. INFORMANT Nicholos V. Mancuso ADDRESS 12717 Fork Rd. Fork, Md. 21051						
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) ASCVD.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c. LOCATION STREET CITY OR TOWN COUNTY STATE						
24. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
25a. SIGNATURE [Signature]					25b. DEGREE MD.			25c. DATE SIGNED 2-11-84.		
26a. PHYSICIAN'S NAME (TYPE OR PRINT) B. D. PAREKH MD.					26b. ADDRESS 1908 HARFORD RD. FALLSTON MD 21047.					
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		27b. DATE 2-14-84		27c. NAME OF CEMETERY OR CREMATORY Fork Meth. Ch. Cem.		27d. LOCATION CITY OR TOWN Baltimore COUNTY Md.				
28. FUNERAL DIRECTOR NAME [Signature] ADDRESS 7401 18th Ave Rd.					29. DATE REC'D. BY REGISTRAR FEB 16 1984					
30. REGISTRAR'S SIGNATURE [Signature]										



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WASHINGTON, D.C.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

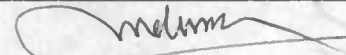
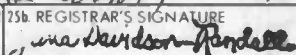
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy, page 1, and submit it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury or other traumatic event, the medical examiner must be called at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

4917

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leona B. Mannas			2a. DATE OF DEATH MONTH DAY YEAR February 27 1984		2b. HOUR 1:45 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG 31 1925		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58		
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND		13b. COUNTY HARFORD		13c. CITY OR TOWN JARRETSVILLE		
14. FATHER'S NAME FIRST MIDDLE LAST CLAUDE C. HOLLINGSHEAD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL MAE CULLY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 447-16-8713		17. INFORMANT ADDRESS FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) External circumscription c by infection 1541 DUE TO, OR AS A CONSEQUENCE OF (b) ca of infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-22 , 19 84 , to 2/27 , 19 84 , that (I) (we) last saw the deceased alive on 2-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 4/27/14		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.W. Ishaque MD		22e. ADDRESS 7005 Union Ave Harford 21227				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/29/84		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES		ADDRESS 8800 HARFORD RD.		25a. DATE REC'D. BY REGISTRAR MAR 2 1984		
				25b. REGISTRAR'S SIGNATURE 		

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M. M. [illegible]

[Faint text at the bottom left, including the date 'MAR 2 1964' and other illegible markings.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM M MARTIN						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR FEB. 12 1984				2b. HOUR 7AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 3 1899		6. AGE (IN YEARS) (LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD FEB. 12 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH CRESWELL				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2034 CALVARY ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOILER OPERATOR		12b. KIND OF BUSINESS U.S. GOV'T	
13a. STATE MARYLAND		13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21014 2034 CALVARY ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST DAVID MARTIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELMINA WILSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 241-26-5752		17. INFORMANT EDWARD W. MARTIN 2201 CALVARY ROAD BEL AIR, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. ASCUN DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Luis E. Renjel</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED FEB. 12, 1984			
EXAMINER'S NAME (TYPE OR PRINT) LUIS E. RENJEL M.D.				ADDRESS 464 ALLIANCE ST. HAVRE DE GRACE MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY MT. ZION METH. CH. CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MARYLAND			
24. FUNERAL DIRECTOR NAME HOWARD K. MCCOMAS III				ADDRESS ABINGDON, MARYLAND				25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04919

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Emily FORMWOOD			2a. DATE OF DEATH MONTH DAY YEAR February 20, 1984			2b. HOUR 2:35 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 19 1890		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YEARS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND			13b. COUNTY HARFORD		13c. CITY OR TOWN JOPPA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM RICHARD HOLLOWAY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET SUSANNAH WATTERS			16. STREET ADDRESS / ZIP CODE 607 MAGNOLIA ROAD 21085			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS BRADFORD W. MCGIBNEY 607 MAGNOLIA RD JOPPA, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 ASGVD IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb 8 , 19 84 , to Feb 20 , 19 84 , that (I) (we) lost saw the deceased alive on Feb 20 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Lee			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Lee			22e. ADDRESS Union Med Clinic						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 23 '84		23c. NAME OF CEMETERY OR CREMATORY DARLINGTON CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE DARLINGTON HARFORD MD.		
24. FUNERAL DIRECTOR NAME HOWARD K. MCCOMAS III			ADDRESS ABINGDON, MARYLAND			25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04920

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HELEN M. McMULLEN			2a. DATE OF DEATH MONTH DAY YEAR 2/24/84			2b. HOUR 9:25P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 / 14 /94		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH HARVE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZEN'S NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY CECIL		13c. CITY OR TOWN NORTH EAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1579 W. OLD PHIL. RD. 21901	
14. FATHER'S NAME FIRST MIDDLE LAST LEWIS C. BLACKBURN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA McLAUGHLIN				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 220-54-5502				17. INFORMANT ADDRESS MRS. JENNIE B. BLACKBURN, NORTH EAST, MD.				21901	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular thrombosis 2dy DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular as thrombosis 1yhr APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) anemia P.A.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/24/83 to 2/24/84 , that (I) (we) last saw the deceased alive on 2/24/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE MD				22c. DATE SIGNED 2/25/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-27-1984		23c. NAME OF CEMETERY OR CREMATORY HOPEWELL METH. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CECIL MARYLAND		
24. FUNERAL DIRECTOR NAME HICKS HOME for FUNERALS, ELKTON, MD. 21921				25a. DATE REC'D. BY REGISTRAR MAR 2 1984					
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

地址：上海

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES EDWARD MILLER SR.			2a. DATE OF DEATH MONTH DAY YEAR 2 15 84		2b. HOUR 3:45 M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 19 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCIENTIFIC ADVISOR		12b. KIND OF BUSINESS OR INDUSTRY FEDERAL GOVERNMENT
13a. STATE MARYLAND		13b. COUNTY HARFORD	13c. CITY OR TOWN BEL AIR	13d. STREET ADDRESS 27 LAKE DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD PERCY MILLER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE DORCAS MULLINEAUX			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 313-18-6987		17. INFORMANT ADDRESS GERTRUDE E. MILLER 27 LAKE DRIVE BEL AIR, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Severe CVD of Pby less - 9 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) — PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 HRS
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1 - 19 84 to 2 - 19 84 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE V. NAIR		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. NAIR		22e. ADDRESS 1716 Harford Road - Fallston - MD 21047			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB. 17, 1984	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VA.	
24. FUNERAL DIRECTOR HOWARD K. MCCOMAS III		25. DATE REC'D. BY REGISTRAR B 21 1984			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, and medical examination must be continued at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Anne C. Moore				2a. DATE OF DEATH MONTH DAY YEAR 2/26/84				2b. HOUR MIN. 12:00			
3. SEX FEMALE		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 3 4 98		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Bayard MD.					
10. CITY OR TOWN OF DEATH Talleston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Talleston Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed at home		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Talleston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4107 St. Clair Bldg			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE HAGNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SMITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) unknown				16b. SOCIAL SECURITY NO. 217488480				17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardio respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCD / pneumonia (c) Senility / Fx hip DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): fractured hip											
19a. DATE OF OPERATION 2/6/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx hip				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:15/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) fx. fall							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home		21f. LOCATION CITY OR TOWN COUNTY STATE St. Clair Harford Md							
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 2/25 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. Natural											
22b. SIGNATURE D. B. Haskins				22c. DEGREE MD				22d. DATE SIGNED 2/26/84			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) D. B. Haskins				22f. ADDRESS 1327 Belair Rd Belair 21014							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/28/84		23c. NAME OF CEMETERY OR CREMATORY MIRLEND MEMORIAL PA				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. COUNTY MD.			
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES				ADDRESS 8800 HARFORD ROAD				25a. DATE REC'D. BY REGISTRAR MAR 2 1984		25b. REGISTRAR'S SIGNATURE John Anderson-Randell	

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MAR 2 1964

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DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be contacted by the funeral director) should be contacted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
NORA MAE MULLINS				2 MONTH 15 DAY 84				6:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		6 - 17 - 17		66		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WEST VIRGINIA		USA				HARFORD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
FAWSTON		FAWSTON GENERAL HOSPITAL				HOUSEWIFE		HOMEMAKER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		13d. CITY OR TOWN	
13a. STATE MD.				13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2429 Rocks Rd.		21050	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
AVERY		AGATHA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					
No		NONE		ORPHA S. MULLINS					
		212-24-2679		2429 Rocks Rd. Forest Hill, Md 21050					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) CARDIAC FAILURE								1 DAY.	
4100									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
HYPOXIC BRAIN DAMAGE. RESPIRATORY FAILURE.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from Feb 4, 19 84, to Feb 15, 19 84, that (I) (we) lost saw the deceased alive on Feb 15, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
A. J. SWEATMAN M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2/15/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
A. J. SWEATMAN		Fallon Sen. Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		2-18-84		BEL AIR MEMORIAL		BEL AIR HARFORD, MD.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOWARD K. MCCOMAS III		P.A. ABINGDON, MD.		FEB 21 1984		June Harrison-Russell			

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YORK

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY - POLLMANN				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 15, 1984		2b. HOUR 2:40A M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 8, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.		
10. CITY OR TOWN OF DEATH HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4149 U-WAY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) LIBRARIAN	12b. KIND OF BUSINESS OR INDUSTRY SUPREME COURT OF NY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4149 U-WAY 21078		
14. FATHER'S NAME FIRST MIDDLE LAST HEINZ POLLMANN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JACOBINE BLEIKERS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 050 22 4525		17. INFORMANT ADDRESS MRS. CHRISTINE R. MERMAGEN SAME AS #13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Car fire</i> 2030 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple myeloma</i> (c) <i>Acute leukemia</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) this hospital attended the deceased from 10-12, 1983 to 2-15, 1984, that (we) last saw the deceased alive on 1-18, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/15/84
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 17 FEBRUARY 84	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE MT. PLEASANT, WESTCHESTER CO. N.Y.	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MARYLAND 21078		24. FUNERAL DIRECTOR ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MARYLAND 21078				

FEB 21 1984 *[Signature]*

Mr. [illegible]
[illegible]
[illegible]

~~Chas. [illegible]~~

FEB 8 1 1904

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04925

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) HELEN GERTRUDE BYLE		2a. DATE OF DEATH MONTH DAY YEAR 02 21 84		2b. HOUR 950 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07 13 10		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD		13b. COUNTY HARFORD		13c. CITY OR TOWN FOREST HILL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH NMN PYLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY OLIVE ICK		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 285348	
17. INFORMANT ADDRESS 1547 COOPTOWN RD.		17. INFORMANT NAME HAROLD L. PYLE		17. INFORMANT ADDRESS FOREST HILL, MD 21050		17. INFORMANT PHONE NO. 21050	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cremora DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure, Multiple Myeloma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION CITY OR TOWN COUNTY STATE		21g. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2 Feb 84 , to 21 Feb 84 , that (1) (we) last saw the deceased alive on 21 Feb 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE T. B. Harrison		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. B. Harrison		22e. ADDRESS FGM		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-24-84	
23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARFORD MD.		24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III		24. FUNERAL DIRECTOR ADDRESS ABINGDON, MD.	
24. FUNERAL DIRECTOR NAME HOWARD K. McCOMAS III		24. FUNERAL DIRECTOR ADDRESS ABINGDON, MD.		25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

04926

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHANCY R Reeves			2a. DATE OF DEATH MONTH DAY YEAR Feb 25 1984		2b. HOUR 9:35 P	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 18 13		
6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		8. CITIZEN OF WHAT COUNTRY? USA		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		10. CITIZEN OF WHAT COUNTRY? USA		11. BALTIMORE CITY OR COUNTY OF DEATH Harford MD		
12. CITY OR TOWN OF DEATH Harford		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Md.		15b. COUNTY Harford		15c. CITY OR TOWN Bel Air		
16. FATHER'S NAME FIRST MIDDLE LAST Edward Reeves		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Callie Choates		18. STREET ADDRESS / ZIP CODE 2148 Thomas Run Rd. 21014		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		20. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 186-14-2919		21. INFORMANT ADDRESS Gloria Perry 148 Farm Rd. Aberdeen, Md.		
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden Death 4409 DUE TO, OR AS A CONSEQUENCE OF Cardiac arrest AN ATERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None						
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:45 P.M. 19 84		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
25a. INJURY OCCURRED: WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c. LOCATION STREET CITY OR TOWN COUNTY STATE 2148 Thomas Run Rd. Bel Air Harford Md.		
26. I certify that (I) (this hospital) attended the deceased from 2/24/84 to 2/25/84 , that (I) (we) last saw the deceased alive on 2/24/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
27a. SIGNATURE Dante M. Monakil		27b. DEGREE MD		27c. DATE SIGNED 2/24/84		
28. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL		29. ADDRESS Harford Md 21078				
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		30b. DATE 3/1/84		30c. NAME OF CEMETERY OR CREMATORY Clark's United Meth.		
31. FUNERAL DIRECTOR NAME ADDRESS Arnold Beard 353 Fountain St. Harford Md.		32. DATE REC'D. BY REGISTRAR FEB 29 1984		33. REGISTRAR'S SIGNATURE J. Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED
U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250



TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[illegible text follows, mostly mirrored bleed-through from the reverse side]

APPROVED: [illegible]
SPECIAL AGENT IN CHARGE
[illegible text]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EMMA ELIZABETH SCHILLING		2a. DATE OF DEATH MONTH DAY YEAR 02 22 84		2b. HOUR 9:20 AM	
1. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 01 23 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY HARFORD	13c. CITY OR TOWN JOPPA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. JACKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA F. RICH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 212031212		17. INFORMANT EDWARD M. SCHILLING JR		ADDRESS 204 DURYEA DR. JOPPA, MD 21085	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest - as stated DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) acute renal failure					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 8 Feb 19 84 , to 22 Feb 19 84 , that (1) (we) last saw the deceased alive on 22 Feb 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harrison		DEGREE MD		22c. DATE SIGNED 22 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harrison		22e. ADDRESS FGH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-25-84		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MD.		23e. DATE REC'D. BY REGISTRAR FEB 23 1984		23f. REGISTRAR'S SIGNATURE John Davidson	
24. FUNERAL DIRECTOR NAME ADDRESS HOWARD K. MCCOMAS III P.A. ABINGDON, MD.					



FOR COLLECTOR

CHITTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MABLE T SCHMIDT					2a. DATE OF DEATH MONTH 2 DAY 20 YEAR 84					2b. HOUR 12³⁰ AM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 8 DAY 22 YEAR 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home keeping		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Harford 13c. CITY OR TOWN Belair					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS 21014 1328 Gateshead Dr. Belair, Md.
14. FATHER'S NAME FIRST Frederick MIDDLE Webster LAST Bridges					15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE M. LAST French					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. 217-12-0309		17. INFORMANT ADDRESS 617-Shore Dr. Mrs. Donna L. Akers, Joppa, Md. 21085						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WOMIA 4278 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE RENAL FAILURE (c) CARDIOGENIC SHOCK										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARDIAC FAILURE, COPD, DIABETES, THYROID CANCER, OBESITY										
19a. DATE OF OPERATION 1/25/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED. ON SICK SINUS SYNDROME			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that AT (this hospital) attended the deceased from JAN 16, 19 84 , to FEB 19, 19 84 , that (I) (was) last saw the deceased alive on 2/19/84 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.										
22b. SIGNATURE A. J. SWEATMAN		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/20/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. J. SWEATMAN				22e. ADDRESS FALLSTON GEN HOSP						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-22-1984		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gar.		23d. LOCATION CITY OR TOWN Belair COUNTY Harford STATE Md.				
24. FUNERAL DIRECTOR NAME L. A. Kingsville, Jr., Md. 21085				25a. DATE REC'D. BY REGISTRAR FEB 23 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

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WILLIAM J. DUFFY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alfred George Schmitt			2a. DATE OF DEATH MONTH DAY YEAR February 21 1984			2b. HOUR 5 ²⁸ / _A M			
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Broker		12b. KIND OF BUSINESS OR INDUSTRY Investment	
13a. STATE Maryland			13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air (2014)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH ANTON Schmitt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary KANNENGEISER			17. INFORMANT (NAME) ADDRESS (Wife) 838-7731 110 SEEVUE Court - Apt. 3 Bel Air, Maryland 21014			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 065-10-0471-A		17. INFORMANT (NAME) ADDRESS Mrs. Margaret W. Schmitt 110 SEEVUE Court - Apt. 3 Bel Air, Maryland 21014				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 43600 DUE TO, OR AS A CONSEQUENCE OF (b) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dr. Lites Melli Kus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2-9 19 84 , to 2-31 19 84 , that (I) (we) last saw the deceased alive on 2-21 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leticia S. Galvez					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leticia S. Galvez, M.D.					22e. ADDRESS 625 S. Union Ave. Havre de Grace, Md. 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 25, 1984		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014		
24. FUNERAL DIRECTOR Joseph William Foster W. Bradley & Williams St. Bel Air, Maryland 21014					25a. DATE REC'D. BY REGISTRAR FEB 23 1984				
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

MEDICAL CERTIFICATION

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11888

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Handwritten notes and text, including "Handwritten notes" and "Handwritten notes".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 4 9 3 0

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT KIRBY SHRAKE			2a. DATE OF DEATH MONTH DAY YEAR February 29, 1984		2b. HOUR 6:00 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 11, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Savanna, Ill.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		
10. CITY OR TOWN OF DEATH Edgewood	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 606 Charwood Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Qua. Assurance Spec. US-govt.		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 606 Charwood Court 21040
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Malachi Shrake			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Mae Hoover		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea 727-09-7357		17. INFORMANT ADDRESS: Edgewood, Md. 21040 Mrs. Dorothy J. Shrake, 606 Charwood Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>White Cardiac - Myo. Arter.</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial CA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CA 1 fup + bridge</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Antonino H. Calon, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb. 29, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Antonino H. Calon, M.D.		22e. ADDRESS 1016 Edgewood Road, Edgewood, Md. 21040			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE Mar. 3, 1984	23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR MAR 2 1984		25b. REGISTRAR'S SIGNATURE <u>W. Davidson Riddell</u>	

3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

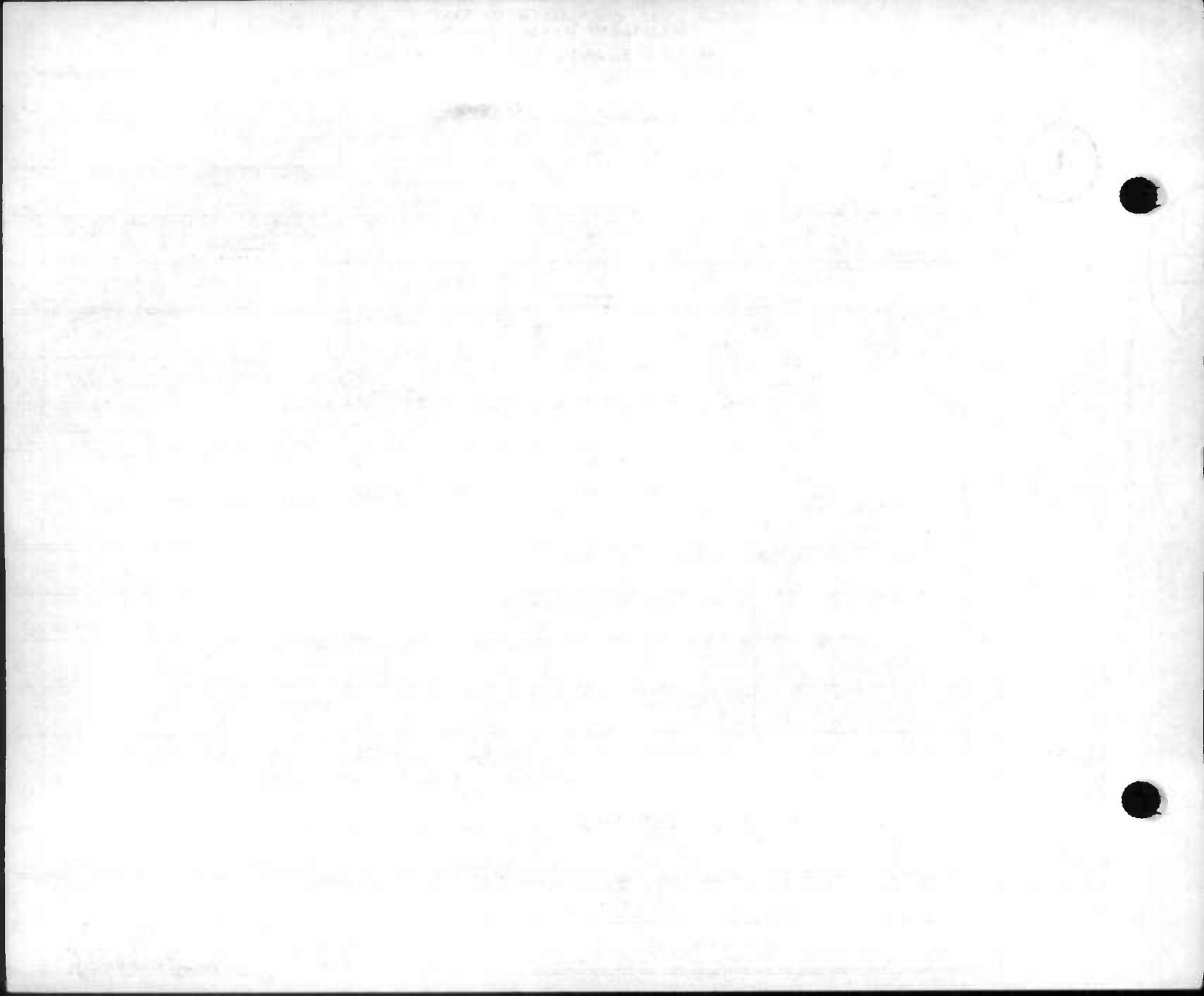
DHMH-17
(VR A15 ME (5))
15M 2/80

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Russell Herbert Silling						ESTIMATED <input checked="" type="checkbox"/> 2-8 1984						8 a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
M	W	2 16 11	72 YRS.	MONTHS DAYS		HOURS MIN		2-8 1984			1 p M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VA			USA						Harford MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)			12b. KIND OF BUSINESS OR INDUSTRY		
Joppa, Md.			1406 Old Mountain Rd.						Retired Supply			Nat. Guard		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD			Harford			Joppa, Md.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21085 1406 Old Mountain Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Theodore Lacy Silling			Bessie Brooke Fisher			215 10 3678			Mary Beth Crisco, 10 Trenton Lane, Bel Air			Md. 21014		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Md. 21014		
Yes			WWII			215 10 3678			Mary Beth Crisco, 10 Trenton Lane, Bel Air			Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
2500 IMMEDIATE CAUSE (a) CORONARY Heart Disease														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) DIABETES - ASCUD														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Luis E. Renjel				M.D. Deputy MEDICAL EXAMINER				2-8-84						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Luis E. Renjel MD				464 Alliance St. Havre De Grace, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial				Feb. 11, 1984		Bel Air Memorial Gardens				Bel Air Harford Md.				
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
Howard K. McComas III, Abingdon, Md. 21009								FEB 10 1984				John J. Connel		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELENA D. Simmons				2a. DATE OF DEATH MONTH DAY YEAR FEB 4 84 2b. HOUR 10:27 AM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1 10 06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 78	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp.		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. - Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3131 Chesterfield Ave. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-14-1197		17. INFORMANT ADDRESS Bernard Simmons, Jr., 505 Camelot Dr. Belair, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Depressive reaction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 83 to 2/4/ 19 84 , that (I) <input checked="" type="radio"/> saw the deceased alive on 2/4/ 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. L. Pirovolidis MD		DEGREE		22c. DATE SIGNED 2/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. L. Pirovolidis		22e. ADDRESS 1716 HARFORD Rd. FALLSTON, Md. 21047			
23a. BURIAL, CREMATION, REMOVAL Entombment		23b. DATE 2/8/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Maus.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25a. DATE REC'D. BY REGISTRAR FEB 7 1984	
		25b. REGISTRAR'S SIGNATURE John J. Chief			

BP

11

20% COTTON FIB

CHRYSLER

11

11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SARA Emma Sincavage			2a. DATE OF DEATH MONTH DAY YEAR February 6, 1984			2b. HOUR 6 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 16, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MINS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Keeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE 626 Rogers St. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert James Hudson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Patience Fisher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-30-9079		17. INFORMANT ADDRESS MD, 21001 Ralph Sincavage, 626 Rogers St., Aberdeen					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease, Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) 5 months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Cachexia, Rheumatoid Arthritis, Diabetic Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR not applicable		21c. DATE OF INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (FACTORIES, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 16 19 84 to 2-6 19 84					
22a. I certify that (I) (this hospital) attended the deceased from 2-6 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE M. M. Lazadn				DEGREE MD				22c. DATE SIGNED 2/6/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAZADN, MANUEL				22e. ADDRESS PO Box 519 Plaw St Aberdeen MD 21001					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro, Caroline, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-338				25a. DATE REC'D. BY REGISTRAR FEB 09 1984		25b. REGISTRAR'S SIGNATURE John E. Smith			

11326

John
John

White
USA

July 10, 1913

to

Book
Book

Robert

James

Hudson

William

William

NO. 2101

215-30-000 Ralph Stinson, 030 Rogers St., Detroit

Handwritten signature

Handwritten signature

Handwritten signature

Handwritten signature

Handwritten signature

Bureau

Feb. 8, 1934

Greenboro Cemetery

Greenboro, Carolina, Maryland

Handwritten signature

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04934

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edith M. Smith			2a. DATE OF DEATH MONTH DAY YEAR Feb 11 1984		2b. HOUR 12 A.M.		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 29 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10. CITY OR TOWN OF DEATH Haure de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Penna.		13b. COUNTY York		13c. CITY OR TOWN Delta		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL WICKS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 213-28-4106		17. INFORMANT ADDRESS Harry R. Smith P.O. Box 165 Delta PA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS OOD 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-4 , 19 84 , to 2-11 , 19 84 , that (I) (we) lost saw the deceased alive on 2-11 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. T. Lee		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb 14	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. T. Lee		22e. ADDRESS Union Med. Clinic, Haure de Grace					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/13/84		23c. NAME OF CEMETERY OR CREMATORY Bryansville		23d. LOCATION CITY OR TOWN COUNTY STATE Bryansville York Pa.	
24. FUNERAL DIRECTOR NAME John H. Harkins		ADDRESS 600 Main Street Delta PA		25. DATE RECEIVED BY REGISTRAR FEB 15 1984			

MEDICAL CERTIFICATION

2752W

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837

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. WITH FORM PM 3, RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4935					
1- FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Randolph NMI Speller Jr.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 2/6/84		2b. HOUR 4:15 AM			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 25 44		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 39		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 39 YRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 6 1984		2d. HOUR 8:30 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford		MD	
10. CITY OR TOWN OF DEATH Havre De Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 812 Locust St. Havre De Grace				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD				13b. COUNTY Harford		13c. CITY OR TOWN HavreDeGrace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 812 Locust St. 21078					
14. FATHER'S NAME FIRST MIDDLE LAST Randolph						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Speller Sr. Estella Rumsey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215 42 7981				17. INFORMANT personal papers				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Luis E. Renjel</i>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 2-6-84			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St.				Havre De Grace, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/11/84		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery				23d. LOCATION CITY OR TOWN COUNTY HavreDeGrace Harford				21078 Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arnold Beard 353 Fountain St. HDG, Md.										25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE <i>Davidson-Rendell</i>			

BP

(A)

CHIL

DOWN

24

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

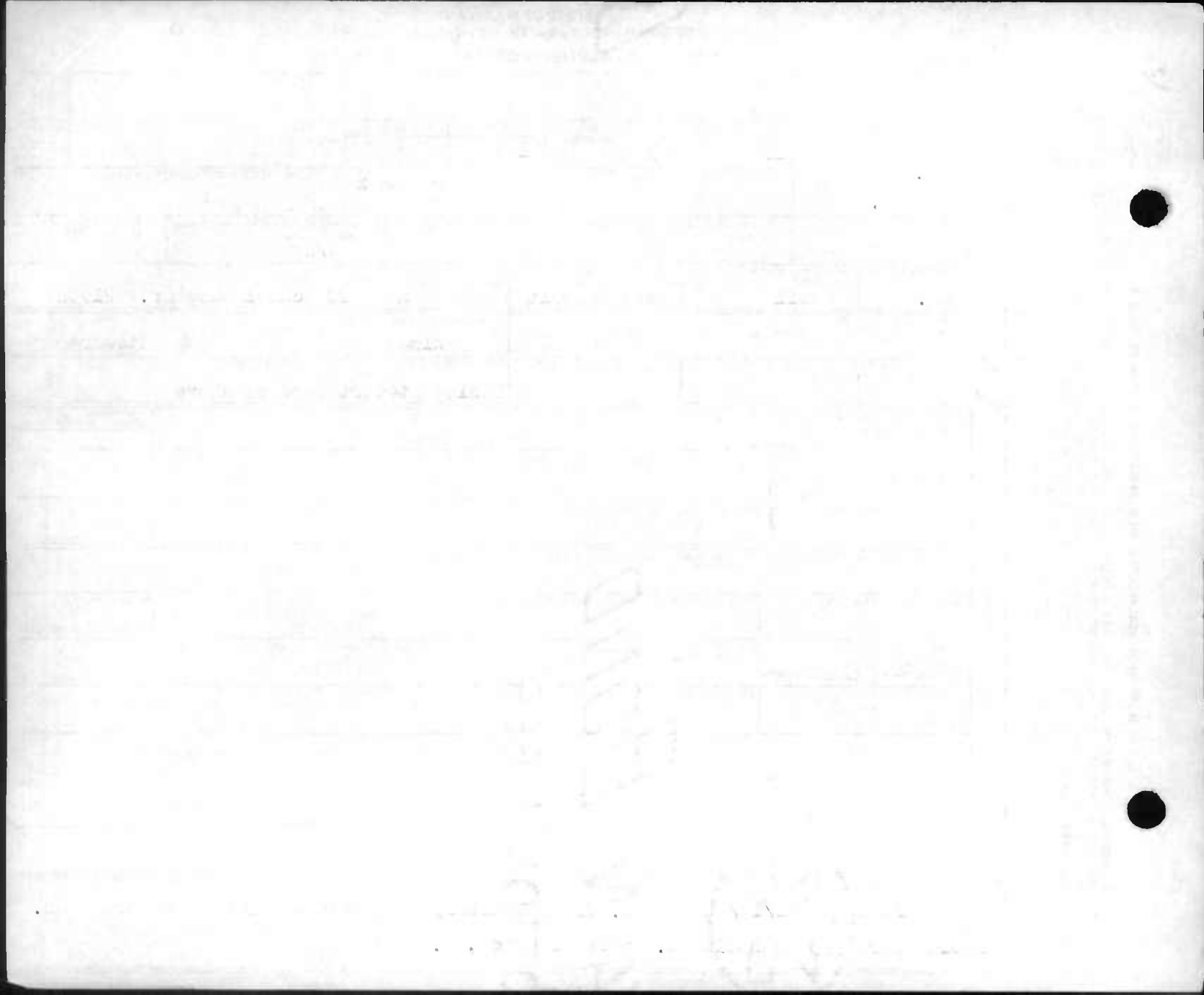
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1 9 1984										2b. HOUR M 6:56A			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Christian Stewart															
3. SEX T		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 1		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 9 1984		7d. HOUR M 6:56A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20 Schoolhouse Dr. 21904					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Denise Stewart									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Denise Stewart same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome 7980 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 1/10/84							
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/13/84		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Havre de Grace Harford Md.					
24. FUNERAL DIRECTOR Arnold Beard 353 Fountain St. Havre de Grace, Md.										25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04937

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>RUTH E. STEPHENSON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2-26-84</i>			2b. HOUR MIN. <i>12:30 P</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 14 1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>77 yrs.</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		9. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i> MD.				
12. CITY OR TOWN OF DEATH <i>HARFORD</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD MEMORIAL HOSPITAL</i>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		15. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Perryville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Aiken Avenue 21903</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>James McCullough</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Owens</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>223-01-0812</i>			17. INFORMANT ADDRESS <i>Jean Lucas Rising Sun, Maryland 21911</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor. to gun school</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarct.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>late atherosclerotic cardiovascular disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Compensatory heart failure</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <i>2-24</i> 19 <i>84</i> , to <i>2-26</i> 19 <i>84</i> that (1) (we) last saw the deceased alive on <i>2-26</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) the body was not autopsied after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE		22c. DATE SIGNED <i>2/26/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Annkowski M.D. 319 So. Lincoln Ave. Hgt. 4621078</i>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 1, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Principio Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Perryville Cecil Maryland</i>					
24. FUNERAL DIRECTOR <i>Lee W. Patterson & Son, Perryville, Maryland</i>					

MAR 05 1984 *[Signature]*

51856

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DOWN

DOWN

MAR 05 2010

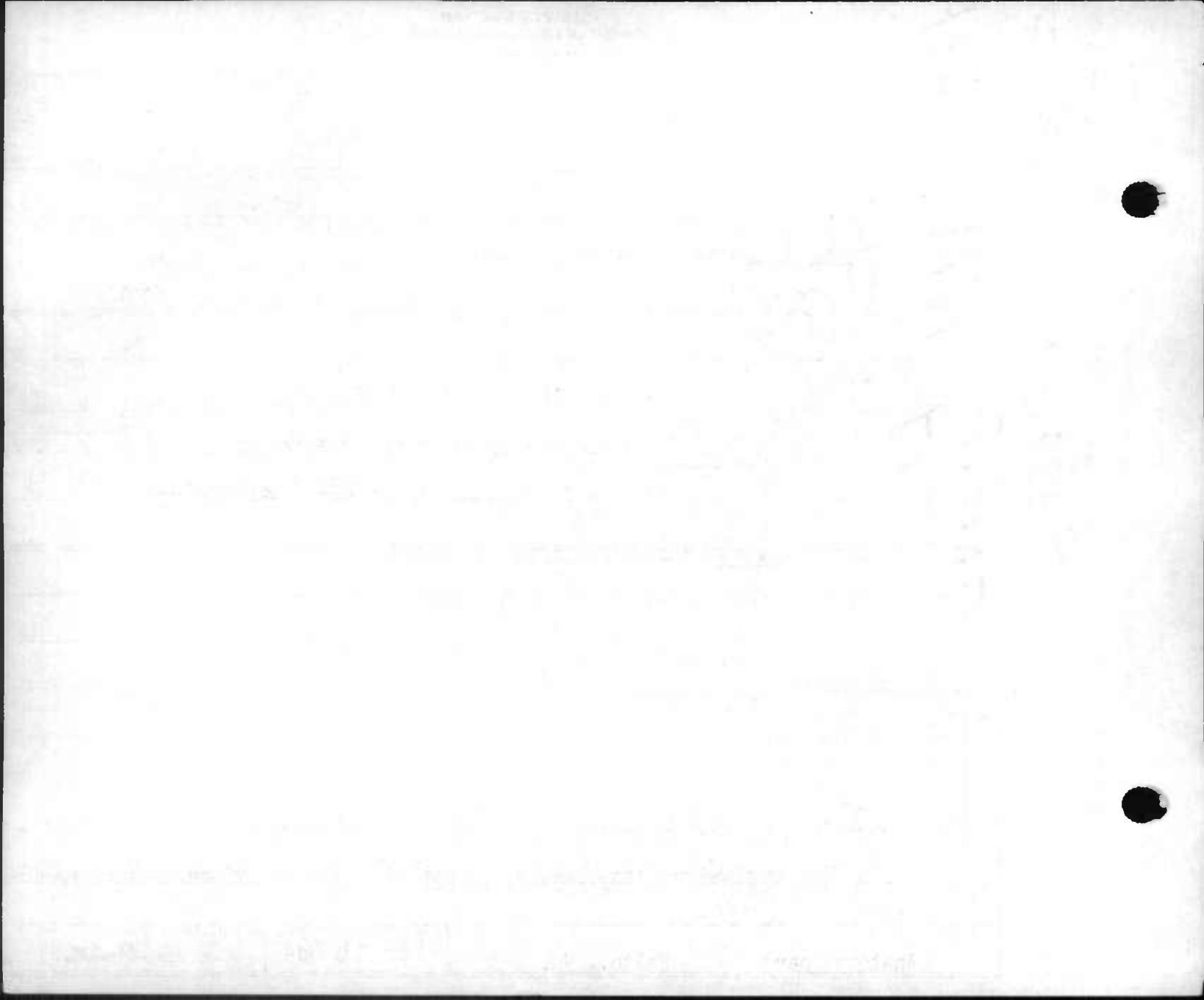
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 04939	
1. FOR STATE REGISTRAR										2b. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer D. Vanhoy										2b. DATE KNOWN OF DEATH ESTI-MATED 2 12 1984	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 28 23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Havre De Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY Cecil		13c. CITY OR TOWN Conowingo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 78 Baldfire Rd. 21918	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 235-26-6611		17. INFORMANT ADDRESS Old hospital chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Chronic alcoholic - GI-bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) Deputy				DATE SIGNED 2-12-84			
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St. Havre De Grace, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 2/15/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY		23e. DATE 21078	
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.						25a. DATE REC'D. BY REGISTRAR FEB 16 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rendell			

MEDICAL CERTIFICATION



BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 04940			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George H. Wagner			
2a. DATE OF DEATH MONTH DAY YEAR 2 2 84		2b. HOUR 10 ¹⁸ P.M.		3. SEX Male		4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hosp	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 1501 Blue House Court		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Maryland Harford Street		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Wagner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 181-14-6450	
17. INFORMANT ADDRESS Lola Wagner, Street, Maryland 21154		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 Cardiac arrest Severe CMI ASLU.D DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CMI.		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 19 84, that (I) (we) lost saw the deceased alive on 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) saw the body after death.		22b. SIGNATURE M.D.		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.S. NAIR	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Maryland	
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, PA 17314		24b. ADDRESS		24c. DATE BY REGISTRAR FEB 07 1984		24d. SIGNATURE John H. Harkins	



TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY,
WASHINGTON, D. C.
FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY,
WASHINGTON, D. C.
SUBJECT: [Illegible]

11/11/11

20%



RECEIVED
JAN 1 1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 04941			
1. FOR STATE REGISTRAR				1. DECEASED NAME			
FIRST MIDDLE LAST Kenneth Roy Weddle				2a. DATE OF DEATH MONTH DAY YEAR Feb 18 1984			
2b. HOUR 9:40 P.M.							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 1, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Hartford		13c. CITY OR TOWN Aberdeen		13d. STREET ADDRESS Aldino-Stepney Rd. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Lemon Wilbert Weddle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosie Ila Turman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. WW II		16c. 225-12-9678		17. INFORMANT ADDRESS Ruby L. Weddle, 525 Aldino-Stepney Rd. Aberdeen, MD 21001			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4110 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Acute coronary insufficiency (c) Arteriosclerotic cardiovascular disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHERE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-18-84 to 2-18-84, that (I) (we) last saw the deceased alive on 2/18/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.							
22b. SIGNATURE H. KAWAKAWA		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. STATE SIGNED Feb 18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. KAWAKAWA		22e. ADDRESS M.D. 319 S. Union Ave. Htg Md. 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial		23b. DATE Feb. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY Weeks Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Willis, Floyd, Virginia	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A.,		ADDRESS Aberdeen, MD, 21001-3359		25. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]
DATE: [Illegible]
[Illegible text block containing administrative details and routing information]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04942

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES Adelaide			FIRST MIDDLE LAST White			2a. DATE OF DEATH MONTH DAY YEAR Feb 19 1984			2b. HOUR 7:05 PM		
3. SEX Female			4. RACE white caucas.			5. DATE OF BIRTH MONTH DAY YEAR 3 2 1895			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.		
10. CITY OR TOWN OF DEATH Bel Air			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker		
13a. STATE MD			13b. COUNTY Harford			13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 605 Plumtree Rd.			13f. CITY OR TOWN Bel Air			13g. STATE MD			13h. ZIP CODE 21014		
14. FATHER'S NAME FIRST MIDDLE LAST James Enoch Archer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Maggie) Margaret Ann Magness			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-24-2269		
16c. ADDRESS 607 Plumtree Road Bel Air, Maryland 21014			17. INFORMANT (NAME) Mr. James T. White			17a. ADDRESS 607 Plumtree Road Bel Air, Maryland 21014			17b. PHONE NO. 838-7022		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBRO-VASCULAR ACCIDENT 4292 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) A.S.C.U. DEHYPERTENSION (c) (DIABETES @ 3 YRS) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 YRS									18a. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 12 FEB 19 84 to 19 FEB 19 84 , that (I) was was saw the deceased alive on 17 FEB 19 84 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above. (If you you did not see the body after death)											
22b. SIGNATURE H.T. Sidwell M.D.						DEGREE			22c. DATE SIGNED 19 FEB 84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.T. SIDWELL M.D.						22e. ADDRESS 401 FRANKLIN ST BEL AIR, MD 21014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 22, 1984			23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Meth. Ch. Cem.			23d. LOCATION (CITY OR TOWN) COUNTY STATE Bel Air, Harford Co., Maryland 21014		
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FEB 23 1984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARITE H. WITTICH			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1984			2b. HOUR 7:00 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 307 Redbud Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Wehr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Miller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 212-05-2889		17. INFORMANT ADDRESS James C. Wittich Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of The Pancreas DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Malabsorption Syndrome							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 83 to JANUARY 19 84 , that (I) (we) last saw the deceased alive on January 25 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Anthony A. Lewandowski M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 02-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anthony A. Lewandowski, M.D.				22e. ADDRESS 7402 York Rd. Towson, Maryland 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Garrison Forest, Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR FEB 28 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glen Carl Wolfe, Sr.		2a. DATE OF DEATH MONTH DAY YEAR 2/12/84		2b. HOUR 9:03 A	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 24 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY McCormick Co.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Perry Hall	
14. FATHER'S NAME FIRST MIDDLE LAST Roy Wolfe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Polly Harris		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 413-26-4278		17. INFORMANT ADDRESS Shirley K. Wolfe 9801 Forge Park Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm 4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac arrest during operation (c) G.A.S.C.V.D. & 2nd coronary bypass surgery DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Carotid artery insuff. lipid				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
19a. DATE OF OPERATION 2/12/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aortic aneurysm		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) OK By DR. Renjel Med. Ex.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/12 19 84 , to 2/12 19 84 , that (I) (we) last saw the deceased alive on 2/12/84 19 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE [Signature]		22c. DATE SIGNED 2/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY H. KWAN		22e. ADDRESS 437 GIRARD ST. Hunt de Grace MD			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Feb. 16, 1984		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE REC'D. BY REGISTRAR 2/12/84			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Md.		25. REGISTRAR'S SIGNATURE [Signature]			

FEB 14 1984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04945

1. FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) MARY M. WOODS			DATE OF DEATH MONTH DAY YEAR 2-8-84		HOUR 5:55 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2-2-99		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.	
10. CITY OR TOWN OF DEATH HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) ASSEMBLY WORK		12b. KIND OF BUSINESS OR INDUSTRY METAL FABRICATION
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	
14. FATHER'S NAME FIRST MIDDLE LAST james MOLLOY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNE ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 10 9189		17. INFORMANT ADDRESS MRS. JEAN EVANS 834 OTSEGO ST. HAVRE de GRACE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 Acute Coronary infarction IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) CH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Angioplasty on - Pulmonary					
19a. DATE OF OPERATION 2/7/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Angioplasty on - Pulmonary		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1974 , 19____, to 2/7/84 , 19____, that (I) (we) last saw the deceased alive on 2/7/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Irvin Wachsmann		DEGREE MD		22c. DATE SIGNED 2/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVIN WACHSMAN, M.D.		22e. ADDRESS 407 SOUTH UNION AVENUE, HAVRE de GRACE, MD. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10 FEBRUARY 84		23c. NAME OF CEMETERY OR CREMATORY MT. ERIN CEMETERY	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE John J. Carver	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the funeral director, page 5 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

04946

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Carrie E Yaboznski</i>		2a. DATE OF DEATH MONTH DAY YEAR 02 04 84 2b. HOUR 834 P.M.	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR August 31, 1902 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford Co., MD.</i>	
10. CITY OR TOWN OF DEATH <i>Fallston</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Fallston Gen Hosp.</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i> 12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>16501 Garfield Rd. 21111</i>	
13a. STATE <i>Maryland</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Monkton</i>	14. FATHER'S NAME FIRST MIDDLE LAST <i>Paul Regula</i> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Angela Magiera</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> 16b. SOCIAL SECURITY NO. <i>213-74-1215</i>	17. INFORMANT ADDRESS <i>Monkton 21111 Stephanie Stecker 16501 Garfield Rd.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4100 Cardio Pulmonary Arrest</i> IMMEDIATE CAUSE (a) <i>Massive Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>2 days</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/4/84</i> to <i>2/4/84</i> , that (I) (we) lost saw the deceased alive on <i>2/4/84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
23a. SIGNATURE <i>Barry Woltz</i> DEGREE <i>MD</i>		23b. DATE SIGNED <i>2/4/84</i>	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BARRY WOLTZ</i>		23d. ADDRESS <i>2303 Belair Rd. Pikesville, MD</i>	
23e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/7/84</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Dippel Funeral Homes, Inc.</i>		25. DATE RECEIVED BY REGISTRAR <i>FEB 6 1984</i> REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

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These particular letters
concerning the same information
are

in the file for the
year 1944
and are also in the file for
the year 1945